
A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

# Doctors of Chiropractic Detailed Report

# 2002-2003

January 2005

# EXECUTIVE SUMMARY

## Goal Achievement

BCBSM met the cost, access and quality of care goals during the reporting period.

### Cost Performance

The two-year average percent change in payments per 1000 members during this period resulted in a decrease of 1.9 percent. The PA 350 cost goal was to limit the increase to 2.9 percent. The major factor affecting cost performance during this reporting period was the decrease in utilization. Both the number of members and percentage of members using the benefit declined, however the number of services per member using the benefit increased.

### Access Performance

There was an appropriate number of participating chiropractors throughout the state to ensure the availability of covered health care services to each BCBSM member. BCBSM maintained a formal participation rate of nearly 87 percent, and a per-claim participation rate of nearly 98 percent. Major factors affecting access performance during this reporting period included:

- Effective communications with chiropractors, such as BCBSM publications and liaison meetings, helped maintain good provider relationships which enhanced participation.

- BCBSM's reimbursement methodology and appeals process are included in the provider manual and participation agreement. Providers are more willing to participate because they know how they will be reimbursed and how to appeal a payment or policy decision if they disagree with BCBSM.

### Quality of Care Performance

BCBSM ensured that chiropractors met and abided by reasonable standards of health care quality. Major factors affecting quality of care performance during this reporting period included:

- Qualification standards required for participation ensured that providers had the appropriate credentials to render chiropractic services.

- Quality control programs such as documentation requirements, retrospective provider profiling and audits helped ensure that only medically necessary care was rendered.

- Effective provider relations including regular meetings of the Physician and Professional Provider Contract Advisory Committee, liaison meetings between BCBSM and representatives from professional chiropractic societies, provider communications, and the provider appeals process kept providers well informed.

# PLAN OVERVIEW

## Providers

Doctors of Chiropractic

## Qualifications

Licensed by the state of Michigan with a Michigan location

## Par Status

Formal or per-claim participation

## Covered Services

Among the procedures that DCs are qualified and licensed to render, BCBSM reimburses for the following medically necessary services: spinal chiropractic manipulative treatment, evaluative and management services, radiologic services to diagnose and treat conditions of the spine and contiguous tissues when the condition is due to spinal misalignment or subluxation, emergency treatment of an acute spinal condition, and mechanical traction when performed with chiropractic manipulative treatment.

## Reimbursement

Based on the lower of the chiropractor's billed charge or the BCBSM maximum payment for covered services.

Most maximum payment levels are based on the Resource Based Relative Value System developed by the Centers for Medicare and Medicaid Services in which services are ranked according to the resource costs needed to provide them.

Maximum payment levels for all DC procedures currently reimbursed by BCBSM are based on RBRVS. If, at any time, BCBSM agrees to reimburse DCs for a procedure for which there is no relative value unit, other factors may be used in setting maximum payment levels, such as comparison to similar services, corporate medical policy decisions, analysis of historical charge data and geographic anomalies. BCBSM may give individual consideration to services involving complex treatment or unusual clinical circumstances in determining a payment that exceeds the maximum payment level.

BCBSM reviews relative values and reimbursement levels periodically and may adjust them as necessary. BCBSM may adjust maximum payment levels based on site of care or BCBSM payment policy.

## Benefit Issues

Prior to 1999, chiropractic benefits included only diagnostic x-rays, manual manipulation of the spine, and certain first aid services. Effective March 1, 1999, BCBSM expanded the scope of payable chiropractic services to include office visits and certain physical therapy modalities. Office services provided on an emergency basis also became payable. This policy change impacted chiropractor utilization by expanding the number of payable services.

Chiropractic services are subject to the benefit restrictions defined by the subscriber's contract. Many group certificates have limits on the number of chiropractic visits that are payable in a calendar year. Mechanical traction procedures are subject to physical therapy limits even if they are provided by a chiropractor. These services are not payable if patients do not have coverage for physical therapy rendered by a professional provider.

## Plan Updates

There were no plan updates during this review period.

# EXTERNAL INFLUENCES

## Market Share

Using the most current data available, Table 1 illustrates BCBSM's commercial (private) market share for members eligible to receive services from a chiropractor in BCBSM's Traditional network. As shown, BCBSM's share of the commercial market in Michigan decreased slightly in every region between 2002 and 2003. Total Traditional market share in Michigan decreased from 10.2 percent in 2002 to 9.6 percent in 2003. This decrease is mainly due to BCBSM members shifting to more managed care products such as PPO and Blue Choice® Point of Service. Although Traditional product membership decreased approximately 57,000 from 2002 to 2003, the net increase in BCBSM's PPO and Point of Service products' membership during the same period was approximately 52,000. The additional loss in the Traditional membership is due to corporate downsizing by BCBSM customers or loss of groups to competitors.

**Table 1**
**Chiropractors Provider Class**
**Traditional Share of Michigan Market**

| | 2003 | | | 2002 | | |
|---|---|---|---|---|---|---|
| **Region** | **Michigan Population*** | **Traditional Chiro Members** | **Market Share** | **Michigan Population*** | **Traditional Chiro Members** | **Market Share** |
| 1 | 3,195,916 | 272,971 | 8.5% | 3,231,013 | 288,051 | 8.9% |
| 2 | 511,051 | 39,365 | 7.7% | 508,175 | 42,885 | 8.4% |
| 3 | 455,977 | 74,139 | 16.3% | 461,277 | 81,540 | 17.7% |
| 4 | 381,597 | 31,460 | 8.2% | 383,655 | 34,780 | 9.1% |
| 5 | 786,781 | 80,207 | 10.2% | 794,361 | 85,128 | 10.7% |
| 6 | 1,025,466 | 98,123 | 9.6% | 1,034,933 | 110,621 | 10.7% |
| 7 | 478,921 | 61,975 | 12.9% | 486,381 | 67,478 | 13.9% |
| 8 | 330,708 | 27,930 | 8.4% | 334,069 | 32,065 | 9.6% |
| 9 | 175,966 | 15,961 | 9.1% | 178,559 | 16,453 | 9.2% |
| **Statewide** | **7,342,383** | **702,130** | **9.6%** | **7,412,423** | **759,000** | **10.2%** |

* Excludes Medicare and Medicaid recipients

## Epidemiological Factors

There is a great deal of overlap among the types of patients seen by chiropractors, family physicians, and orthopedists particularly relating to back pain, neck pain, and headache. In an era when more people are gravitating towards a holistic style of healthcare, chiropractic is becoming a popular form of healthcare.[1]

However, while chiropractors are the largest source of office-based care in the United States that does not involve a physician, people do not view chiropractors as primary care providers of health care or advice. Unlike the care given by primary care providers, the majority of care provided by chiropractors is limited to musculoskeletal problems.[2]

Low back pain is one of the most common ailments in the United States. Four out of five adults suffer back pain sometime in their lives. Costs attributable to back pain are between $50 and $100 billion per year, including medical care, lost wages, disability pay and retraining. Back pain is the number one cause of disability for Americans under age 45.[3]

Chiropractors report that one-third of all patients suffering from back pain choose chiropractors over physicians to treat them, and chiropractors provide 40 percent of primary care for back pain. In addition, chiropractors claim to retain a greater proportion of their patients for subsequent episodes of back pain care than do other providers. [4]

According to the National Institute of Health, research studies of chiropractic treatment for low-back pain have been of uneven quality and insufficient to allow firm conclusions. The data indicate that chiropractic treatment and conventional medical treatments are about equally helpful for low-back pain. It is difficult to draw conclusions about the relative value of chiropractic medicine for other clinical conditions.[5]

The popularity of chiropractic care has fueled an increase in the number of chiropractors. The number of chiropractors formally participating with BCBSM increased over 10 percent from 2001 to 2003. Nationally, the number of chiropractors is expected to grow from approximately 60,000 in 2002[6] to over 100,000 by the year 2010.[7] At this rate, chiropractors will represent a larger proportion of health care professionals in the future.

Chiropractic care is expected to grow as consumer demand for alternative medicine grows. Chiropractors emphasize the importance of healthy lifestyles and do not prescribe medications or perform surgery. Chiropractic treatment of back, neck, extremities, and other joint damage has become more accepted as a result of recent research and changing attitudes about alternative,

[1] www.chiropractic.ac.nz/noframes/nf_chiro.htm
[2] American Family Physician, June 1, 2004
[3] *Living Healthy*, Fall 2002, p. 16
[4] http://www.ahcpr.gov/research/nov95/dept7.htm
[5] http://nccam.nih.gov/health/chiropractic.index.htm
[6] http://www.chiropractic.org
[7] http://www.chiroweb.com

noninvasive health care practices. The rapidly expanding older population, with its increased likelihood of mechanical and structural problems, also will increase demand for chiropractors.[8]

## Economic Factors

National Health Expenditures

National health expenditures rose 9.3 percent in 2002 and were projected to have risen 7.8 percent in 2003. Chiropractors are part of the physician and clinical services component of these figures, which rose 7.7 percent in 2002 and 6.8 percent in 2003.[9]

Health Care Cost Containment

Cost controls were implemented in the benefit structure. Under most certificates, chiropractic benefits had specific visit limitations. Also, utilization management programs and the physician retrospective profiling program monitored provider practice trends and addressed unusual increases in utilization.

Federal, State and Professional Regulation

On December 30, 2002, PA 734 of 2002 went into effect. This law amended sections 16261, 16401, and 16411 of the Michigan Public Health Code to protect consumers by ensuring that only licensed, qualified practitioners provide chiropractic care. This bill was supported by both the Michigan Chiropractic Society and the Michigan Chiropractic Association. This law protects the chiropractic profession by prohibiting an individual from promoting himself as being able to perform chiropractic services unless that person is a licensed doctor of chiropractic. The scope of practice language for chiropractic was modified to include the word "chiropractic" before the term "adjustment." Other provisions were added to avoid scope-of-practice conflicts for veterinarians and osteopaths and to clear up misinterpretations of the law as it relates to other professions.

Other Programs

The Michigan Chiropractic Association's WorkSafe program was implemented in 2002. This program was developed through a grant from Michigan's Department of Labor and Economic Growth. WorkSafe provides free workplace safety training to the state's manufacturing, road construction and nursing home companies. The program targets smaller companies, which often lack the resources to provide training on spinal safety and proper ergonomics.

[8] http://stats.bls.gov/oco/text/ocos071.txt
[9] http://www.cms.hhs.gov/statistics/nhe/projections-2003/t2.asp

# COST GOAL PERFORMANCE

"Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth." This is expressed by the following formula:

$$\left( \frac{(100 + I) * (100 + REG)}{100} \right) - 100$$

## PA 350 Cost Objectives

### Objective 1

To strive toward limiting the increase in total Chiropractor (DC) payments per member to the compound rate of inflation and real economic growth as specified in Public Act 350, giving consideration to Michigan and national health care market conditions.

### Objective 2

To provide equitable reimbursement to DCs in return for high quality services which are medically necessary and delivered to Blue Cross Blue Shield of Michigan (BCBSM) subscribers at a reasonable cost**.**

### Objective 3

Each year retrospective profiles are made available to providers upon request. (See quality section p. 26)

### Objective 4

BCBSM makes a good faith effort to enforce the per case participation rule in Section 502 (1)(b) of PA 350 through its audit activities, its provider inquiry and provider consultant activities, and through responses to all complaints. BCBSM will annually report its efforts to enforce the rule and identify any violations that have occurred. (See access section p. 19)

# Performance - Cost Goal and Objectives

The cost goal for the reporting period was met for the doctors of chiropractic provider class. The cost performance during reporting period 2002-2003 is shown in Table 2.

**Table 2**
**Chiropractors Provider Class**
**2003-2001 Performance Against Cost Goal**

| | 2003 | 2002 | 2001 |
|---|---|---|---|
| **Payments** | | | |
| Total | $33,859,374 | $36,655,347 | $40,300,405 |
| Per 1,000 members | $48,223.80 | $48,294.27 | $50,150.14 |
| % change | -0.1% | -3.7% | |
| **Services** | | | |
| Total | 1,067,967 | 1,155,231 | 1,354,780 |
| Per 1,000 members | 1,521.04 | 1,522.04 | 1,685.90 |
| % change | -0.1% | -9.7% | |
| **Payment/Service** | $31.70 | $31.73 | $29.75 |
| % change | -0.1% | 6.7% | |
| **Members** | 702,130 | 759,000 | 803,595 |
| **Achievement of Cost Goal** | | | |
| Two Year Average Percent Change: | -1.9% | ***2003 percent of Total Payout reported to OFIS**** | **0.9%** |
| **P.A. 350 Cost Goal** | **2.9%** | | |
| **Goal Met** | | ***2003 ASC Business*** | **29.4%** |

*Payout reported to OFIS includes Traditional claims for the hospital, MD, DO, clinical laboratory, fully licensed psychologist, podiatrist, chiropractor and outpatient psychiatric care provider classes. Traditional, PPO and POS claims are included for the SNF, substance abuse, home health care, rehabilitation therapy, ASF, hospice, ESRD, DME/P&O, ambulance, nurse specialists, HIT, dental, vision, hearing and pharmacy provider classes. See the technical notes section for more details.

The average decrease of 1.9 percent in payments per 1000 members was the result of an average decrease in services per 1000 members of 4.9 percent and an average increase of 3.3 percent in payment per service.

Nearly all of the decreases in payments and services per 1000 members during the two-year period occurred in 2002. Payments and services per 1000 members remained essentially the same in 2003 compared to 2002.

Analysis of these trends is discussed in more detail in this report. See Appendix C for additional tables applicable to the cost section.

## Reimbursement

Each year, maximum payment levels were recalculated to take into account actual utilization and new relative value units that the Center for Medicare and Medicaid Services assigned to procedure codes. The process involves BCBSM budget neutral conversion factor calculations prior to adding an increase to each procedure code. This increase was 2.0 percent in both 2002 and 2003. This process does not necessarily result in an increase in maximum payment level for each procedure code.

## Membership

Membership decreased over the two-year reporting period as members continued to move into managed care programs. Other factors contributing to the membership decline include corporate downsizing of BCBSM customers and loss of groups to competitors.

The number of members using chiropractic services decreased steadily from 122,620 in 2001 to 104,370 in 2002 and to 89,433 in 2003. The percentage of eligible members using the benefit also decreased from 15.3 percent in 2001 to 13.8 percent in 2002 and to 12.7 percent in 2003. Both the decreases in the number and percentage of members using chiropractic services contributed to the overall reduction in services per 1000 members of 9.7 percent in 2002 and 0.1 percent in 2003.

In contrast, the number of services per patient increased during the reporting period, from 11 services per patient in 2001 to 11.9 services per patient in 2003.

## Major Procedures

Trends in chiropractors' performance were driven by the utilization of chiropractic manipulative treatment; spinal procedures for various numbers of regions. These services were the primary services rendered by chiropractors representing 81 percent of the total payment in 2003 and 77 percent in 2002.

Payment per service for spinal manipulation tracked with the overall payment per service for this provider class, with increases of 6.6 percent in 2002 and 0.3 percent in 2003, with an average of 3.4 percent.

Tables 3 through 5 show the annual experience for the top ten procedures in detail. Table 6 summarizes reporting period experience by procedure category.

## Table 3
## Chiropractors Provider Class
## 2003 Top 10 Procedures

| Procedure Code | Description | Total Payments | Total Services | Pymts/1000 | Svcs/1000 | Pymt/Srv | % of Total Payments |
|---|---|---|---|---|---|---|---|
| 98941 | Chiropractic manipulative treatment (CMT); spinal, three to four regions | $18,608,353 | 558,168 | $26,503 | 794.96 | $33.34 | 55.0% |
| 98942 | Chiropractic manipulative treatment (CMT); spinal, five regions | $5,314,241 | 120,230 | $7,569 | 171.24 | $44.20 | 15.7% |
| 98940 | Chiropractic manipulative treatment (CMT); spinal, one to two regions | $3,347,641 | 141,539 | $4,768 | 201.59 | $23.65 | 9.9% |
| 97012 | Application of a modality to one or more areas; traction, mechanical | $2,456,632 | 144,263 | $3,499 | 205.46 | $17.03 | 7.3% |
| 72100 | Radiological examination, spine, lumbosacral; two or three views | $706,809 | 17,905 | $1,007 | 25.50 | $39.48 | 2.1% |
| 72070 | Radiological examination, spine; thoraic, two views | $565,969 | 14,863 | $806 | 21.17 | $38.08 | 1.7% |
| 72050 | Radiological examination , spine, cervical; minimum of four views | $502,819 | 9,257 | $716 | 13.18 | $54.32 | 1.5% |
| 72040 | Radiological examination , spine, cervical; two or three views | $470,922 | 13,095 | $671 | 18.65 | $35.96 | 1.4% |
| 72010 | Radiological examination, spine, entire, survey study, anteroposterior and lateral | $383,839 | 5,699 | $547 | 8.12 | $67.35 | 1.1% |
| 72170 | Radiological examination, pelvis; one or two views | $285,673 | 9,138 | $407 | 13.01 | $31.26 | 0.8% |
| All Others | All Others | $1,216,476 | 33,810 | $1,733 | 48.15 | $35.98 | 3.6% |
| **Total** | | **$33,859,374** | **1,067,967** | **$48,224** | **1,521.04** | **$31.70** | **100.0%** |

## Table 4
## Chiropractors Provider Class
## 2002 Top 10 Procedures

| Procedure Code | Description | Total Payments | Total Services | Pymts/1000 | Svcs/1000 | Pymt/Srv | % of Total Payments |
|---|---|---|---|---|---|---|---|
| 98941 | Chiropractic manipulative treatment (CMT); spinal, three to four regions | $18,624,830 | 554,782 | $24,539 | 730.94 | $33.57 | 50.8% |
| 98942 | Chiropractic manipulative treatment (CMT); spinal, five regions | $5,090,512 | 116,353 | $6,707 | 153.30 | $43.75 | 13.9% |
| 98940 | Chiropractic manipulative treatment (CMT); spinal, one to two regions | $4,533,396 | 180,650 | $5,973 | 238.01 | $25.09 | 12.4% |
| 97012 | Application of a modality to one or more areas; traction, mechanical | $3,071,510 | 167,740 | $4,047 | 221.00 | $18.31 | 8.4% |
| 72100 | Radiological examination, spine, lumbosacral; two or three views | $856,048 | 21,790 | $1,128 | 28.71 | $39.29 | 2.3% |
| 72070 | Radiological examination, spine; thoraic, two views | $731,990 | 18,642 | $964 | 24.56 | $39.27 | 2.0% |
| 72050 | Radiological examination , spine, cervical; minimum of four views | $672,584 | 12,092 | $886 | 15.93 | $55.62 | 1.8% |
| 72040 | Radiological examination , spine, cervical; two or three views | $573,936 | 15,663 | $756 | 20.64 | $36.64 | 1.6% |
| 72010 | Radiological examination, spine, entire, survey study, anteroposterior and lateral | $464,430 | 6,722 | $612 | 8.86 | $69.09 | 1.3% |
| 72170 | Radiological examination, pelvis; one or two views | $371,617 | 11,679 | $490 | 15.39 | $31.82 | 1.0% |
| All Others | All Others | $1,664,495 | 49,118 | $2,193 | 64.71 | $33.89 | 4.5% |
| **Total** | | **$36,655,347** | **1,155,231** | **$48,294** | **1,522.04** | **$31.73** | **100.0%** |

**Table 5**
**Chiropractors Provider Class**
**2001 Top 10 Procedures**

| Procedure Code | Description | Total Payments | Total Services | Pymts/1000 | Svcs/1000 | Pymt/Srv | % of Total Payments |
|---|---|---|---|---|---|---|---|
| 98941 | Chiropractic manipulative treatment (CMT); spinal, three to four regions | $19,819,273 | 619,728 | $24,663 | 771.19 | $31.98 | 49.2% |
| 98940 | Chiropractic manipulative treatment (CMT); spinal, one to two regions | $5,544,877 | 231,568 | $6,900 | 288.17 | $23.94 | 13.8% |
| 98942 | Chiropractic manipulative treatment (CMT); spinal, five regions | $4,615,487 | 111,973 | $5,744 | 139.34 | $41.22 | 11.5% |
| 97012 | Application of a modality to one or more areas; traction, mechanical | $3,867,395 | 225,957 | $4,813 | 281.18 | $17.12 | 9.6% |
| 72100 | Radiological examination, spine, lumbosacral; two or three views | $973,877 | 25,602 | $1,212 | 31.86 | $38.04 | 2.4% |
| 72070 | Radiological examination, spine; thoraic, two views | $842,093 | 21,839 | $1,048 | 27.18 | $38.56 | 2.1% |
| 72050 | Radiological examination , spine, cervical; minimum of four views | $777,809 | 14,339 | $968 | 17.84 | $54.24 | 1.9% |
| 72040 | Radiological examination , spine, cervical; two or three views | $637,217 | 17,756 | $793 | 22.10 | $35.89 | 1.6% |
| 72010 | Radiological examination, spine, entire, survey study, anteroposterior and lateral | $560,166 | 8,383 | $697 | 10.43 | $66.82 | 1.4% |
| 72170 | Radiological examination, pelvis; one or two views | $426,073 | 13,700 | $530 | 17.05 | $31.10 | 1.1% |
| All Others | All Others | $2,236,140 | 63,935 | $2,783 | 79.56 | $34.98 | 5.5% |
| **Total** | | **$40,300,405** | **1,354,780** | **$50,150** | **1,685.90** | **$29.75** | **100.0%** |

## Benefits

Under most certificates, chiropractic benefits had specific visit limitations. Prior to 1999, chiropractic benefits included only diagnostic x-rays, manual manipulation of the spine, and certain first aid services. Effective March 1, 1999, BCBSM expanded the scope of payable chiropractic services to include office visits and certain physical therapy modalities. Office services provided on an emergency basis also became payable. This policy change impacted chiropractor utilization by expanding the number of payable services. For the Traditional coverage included in this report, services per 1000 members increased 10.1 percent in 2000 and another 16 percent in 2001 but a 9.7 decrease in 2002 followed by a 0.1 percent decrease in 2003 indicates that this trend is leveling out.

## Utilization

Trends for this reporting period showed a significant decline in overall utilization of covered chiropractic services in 2002 of 9.7 percent. Utilization per 1000 members in 2003 was virtually unchanged compared to 2002. This combined for an average decrease in services per 1000 members during the reporting period of 4.9 percent.

Spinal manipulation, which accounted for over 77 percent of the payout, had a two-year average decrease in utilization of 1.2 percent due to an increase in 2003 of 4.1 percent and a decrease in 2002 of 6.4 percent. During the reporting period, radiologic exam utilization had a two-year average decrease of 11.4 percent and a mechanical traction utilization decrease of 14.2 percent, while accounting for 11.5 percent and 8.5 percent of the payout, respectively. Office visits and other services also saw significant

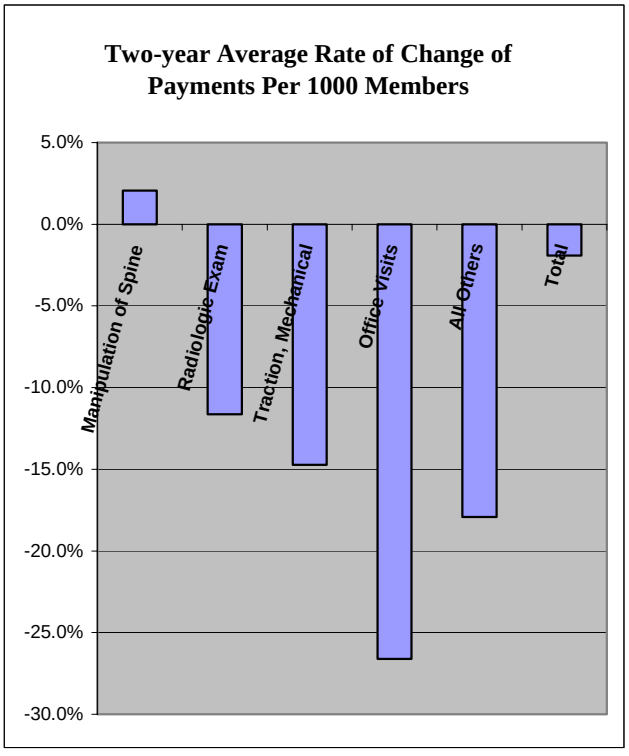
declines in utilization, but accounted for an insignificant portion of payout. Table 6 summarizes the two-year average experience by type of service. Further details on a year-by-year basis are available in Appendix C.

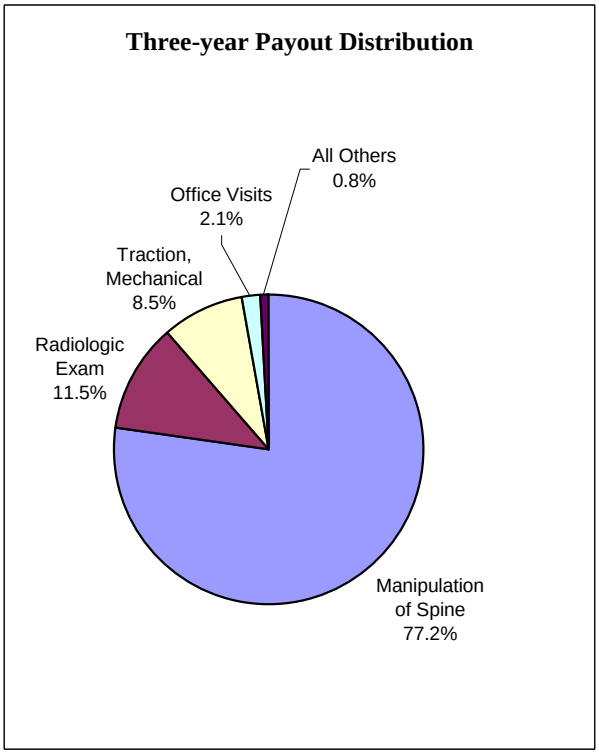
## Place of Service

The majority of the services (over 99 percent in each year of this reporting period) rendered by chiropractors are performed in the office setting. Detailed experience by place of service is located in Appendix C.

## Table 6
## Chiropractors Provider Class
## 2003/2001 Average Rates of Change by Procedure Category

| Procedure Category | Two-year average rate of change | | | Three-year Payout | % of Total Payout |
|---|---|---|---|---|---|
| | Payments Per 1000 Members | Services Per 1000 Members | Payment Per Service | | |
| Manipulation of Spine | 2.1% | -1.2% | 3.4% | $ 85,500,205 | 77.2% |
| Radiologic Exam | -11.6% | -11.4% | -0.3% | $ 12,706,483 | 11.5% |
| Traction, Mechanical | -14.7% | -14.2% | 0.0% | $ 9,395,536 | 8.5% |
| Office Visits | -26.6% | -31.7% | 7.5% | $ 2,281,552 | 2.1% |
| All Others | -17.9% | -15.7% | 0.3% | $ 931,350 | 0.8% |
| **Total** | **-1.9%** | **-4.9%** | **3.3%** | **$ 110,815,126** | **100.0%** |



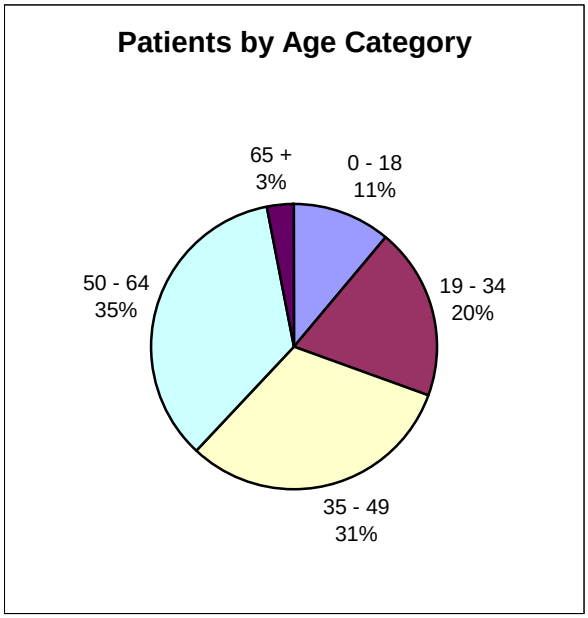
## Analysis of Patients by Age

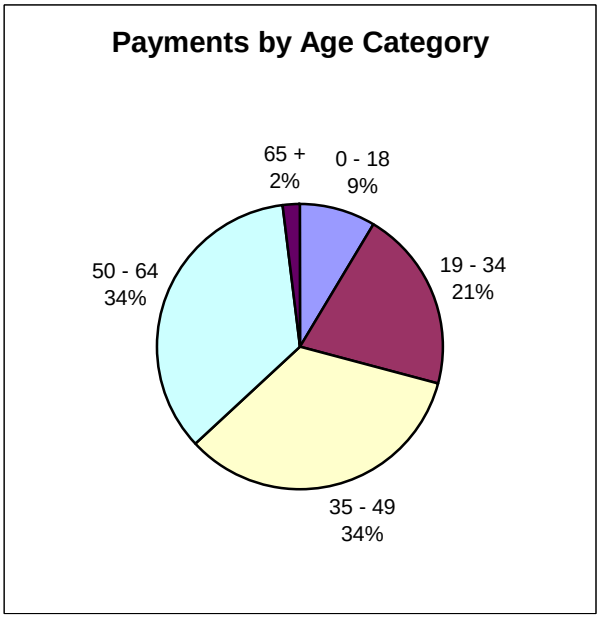
In 2003, 89,433 members, or 12.7 percent of the total membership eligible for chiropractic benefits, obtained services. In 2002, 104,370 members, or 13.8 percent obtained covered chiropractic services. These percentages are relatively high compared to a 2002 nationwide government survey that showed approximately 8 percent of US adults use chiropractic care.[10]

Table 7 below indicates that most chiropractic patients covered by BCBSM are aged 50-64, with a significant concentration aged 35-49. Age category 65+ is only 1 percent because the majority of people in this group are covered by Medicare.

**Table 7**
**Chiropractors Provider Class**
**2003 Patient Count and Payment by Age Category**

| Age Category | Patients | Payments |
|---|---|---|
| 0 - 18 | 9,837 | $2,932,806 |
| 19 - 34 | 17,606 | $6,966,394 |
| 35 - 49 | 28,077 | $11,498,022 |
| 50 - 64 | 31,164 | $11,837,816 |
| 65 + | 2,749 | $624,336 |
| **Total** | **89,433** | **$33,859,374** |




[10] http://www.cdc.gov/nhcs/pressroom/04news/adultsmedicine.htm

## BCBSM Achievement of Cost Goal

The cost goal for the chiropractors' provider class was met for this reporting period as services per 1000 members and price per service remained virtually flat in 2003 while services per 1000 members declined 9.7 percent and price per service increased 6.7 percent in 2002. The impact of utilization and price per service on the two-year average payment per 1000 members was a decrease of 1.9 percent which was below the PA 350 cost goal of limiting the increase to 2.9 percent or less.

# ACCESS GOAL PERFORMANCE

"There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

## PA 350 Access Objectives

### Objective 1

Ensure adequate availability of high-quality medical services, throughout the state, at a reasonable cost to BCBSM subscribers.

### Objective 2

Maintain a reimbursement methodology in accordance with the Physician and Professional Provider Participation Agreement that is based on the lesser of billed charges or BCBSM's maximum payment schedule.

### Objective 3

BCBSM will review reimbursement levels at least every 12 months.

An alternative reimbursement arrangement is available to groups through the Medical Surgical (MS-90) program. The MS-90 program was designed to increase reimbursement levels for purposes of reducing out-of-pocket payments in regions where participation rates were low.

### Objective 4

Maintain and periodically update the directory of participating physicians and professional providers.

### Objective 5

Maintain and update, as necessary, in the Physician's Manual, a "Providers' Bill of Rights" explaining: (1) a provider's right to a managerial level conference under PA 350; (2) how the managerial level conference process works and the timeframes involved under it; (3) when the PA 350 process can be invoked; (4) how this process relates to the other processes described in the contract. This communication will emphasize that a managerial level conference is a right guaranteed by law to every provider and that arbitration is an alternative to this right.

## Performance - Access Goal and Objectives

BCBSM maintained a good participation rate with chiropractors in all regions of the state. This is attributable to BCBSM's effective communications with chiropractors, and BCBSM's reimbursement methodology.

Meetings with the Michigan Chiropractic Association and the Michigan Chiropractic Society enabled providers to maintain an open dialogue with BCBSM. These groups met twice with BCBSM in 2002. No meetings were held in 2003. Topics discussed included reimbursement issues, an update on the new chiropractors' manual, HIPAA, audits, departicipation from the PPO network, workers' compensation, and chiropractic use management.

BCBSM publications conveyed current information to participating providers regarding BCBSM policies and procedures. These communications included an up-to-date provider manual and monthly distribution of *The Record.* An appeals process, as described in the *Guide for Chiropractors,* allowed providers an opportunity to resolve claims and audit disputes. More details on BCBSM's communications with providers are included in the Quality of Care section of this report.

A provider directory and the BCBSM Web site offered members the information necessary to locate a participating provider.

BCBSM's reimbursement methodology was also important in maintaining participation levels. BCBSM reimbursed DCs for covered services deemed medically necessary by BCBSM as described in the Physician and Professional Provider Participation Agreement. DCs were reimbursed the lower of the billed charge or the maximum payment level published in BCBSM's maximum payment schedule. Reimbursement levels were reviewed annually during the reporting period. This process is described in the cost goal section on page 10.

## Participating Providers

Chiropractors who participate with BCBSM on a formal basis must meet BCBSM qualification standards and sign the Physician and Professional Providers Participating Agreement found in Appendix E of this report. The qualification standards are outlined in the Quality of Care Performance Section of this report.

Formal participation rates are derived by comparing the number of formally participating providers to the number of total licensed providers registered with BCBSM. Formal participation by region is summarized in Table 8 for years 2003 and 2002. A regional map defining the PA 350 regions is located in Appendix D. The map on page 21 illustrates the 2003 distribution of participating chiropractors.

**Table 8**
**Chiropractors Provider Class**
**Access Performance 2003 to 2002**

| Region | 2003 | | | 2002 | | |
|---|---|---|---|---|---|---|
| | Number of Participating Providers | Total Providers | Participation Rate | Number of Participating Providers | Total Providers | Participation Rate |
| **1** | 758 | 850 | 89.2% | 709 | 803 | 88.3% |
| **2** | 113 | 134 | 84.3% | 105 | 127 | 82.7% |
| **3** | 113 | 119 | 95.0% | 108 | 113 | 95.6% |
| **4** | 90 | 98 | 91.8% | 87 | 98 | 88.8% |
| **5** | 177 | 213 | 83.1% | 166 | 199 | 83.4% |
| **6** | 197 | 243 | 81.1% | 190 | 235 | 80.9% |
| **7** | 101 | 117 | 86.3% | 98 | 111 | 88.3% |
| **8** | 119 | 141 | 84.4% | 114 | 135 | 84.4% |
| **9** | 49 | 66 | 74.2% | 46 | 65 | 70.8% |
| **Statewide** | **1,717** | **1,981** | **86.7%** | **1,623** | **1,886** | **86.1%** |

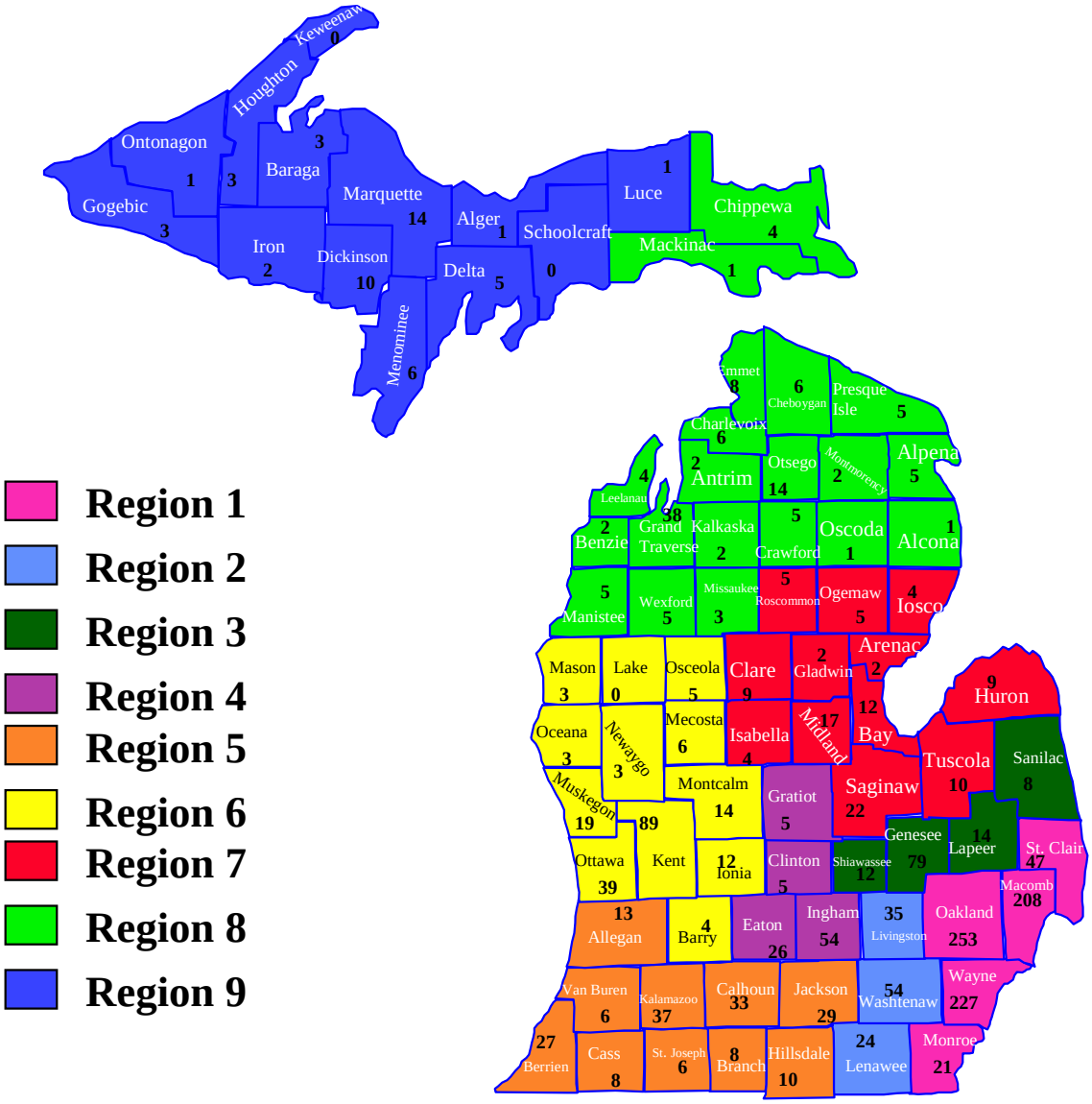
As shown, participation rates have been stable in nearly every region, with overall participation of nearly 87 percent in 2003. The number of participating providers and total licensed providers both increased over five percent. Participation rates were derived by comparing the number of formally participating providers with the total of licensed providers registered with BCBSM.

Per-claim participation is another way to measure access for this provider class. Pursuant to PA 350, chiropractors who participated on a per-claim basis must have accepted payment from BCBSM as payment in full. The PA 350 per-claim law requires that when a provider participates on a per-claim basis for a particular procedure, he or she must continue to participate for all other claims involving that procedure for the remainder of the calendar year. Table 9 shows that per-claim participation, measured as a ratio of services paid in full to total services paid, was over 97 percent during the reporting period.

**Table 9**
**Chiropractors**
**Per-claim Participation Rates**

| Region | 2003 | | | 2002 | | |
|---|---|---|---|---|---|---|
| | **Total Services Paid** | **Services Paid in Full** | **Per-Claim Rate** | **Total Services Paid** | **Services Paid in Full** | **Per-Claim Rate** |
| **1** | 390,370 | 380,199 | 97.4% | 419,423 | 409,309 | 97.6% |
| **2** | 66,070 | 63,948 | 96.8% | 74,159 | 71,476 | 96.4% |
| **3** | 78,080 | 77,029 | 98.7% | 79,617 | 78,742 | 98.9% |
| **4** | 55,258 | 54,146 | 98.0% | 64,677 | 63,180 | 97.7% |
| **5** | 155,919 | 152,025 | 97.5% | 156,536 | 152,351 | 97.3% |
| **6** | 175,291 | 171,265 | 97.7% | 182,161 | 177,956 | 97.7% |
| **7** | 71,176 | 69,878 | 98.2% | 82,599 | 81,038 | 98.1% |
| **8** | 55,893 | 54,772 | 98.0% | 69,455 | 67,056 | 96.5% |
| **9** | 19,910 | 18,675 | 93.8% | 26,603 | 24,238 | 91.1% |
| **Statewide** | **1,067,967** | **1,041,938** | **97.6%** | **1,155,231** | **1,125,346** | **97.4%** |

# 2003 Chiropractors Access by County



## Other Access Issues

The ratio of chiropractors to the general Michigan population, based on the Bureau of the Census figures, is estimated to be one chiropractor for every 5,242 citizens.[11]

Procedures rendered by chiropractors could also be obtained from other providers of health care such as MDs, DOs and physical therapists. Services rendered by other provider classes are reported under their respective provider class plans.

## BCBSM Reimbursement Methodology

BCBSM's goal is to make it easy for providers to work with BCBSM by providing them with the tools and information needed to render quality care using the best available technologies. This includes a payment policy that provides incentives for high-quality and cost-effective care.

BCBSM reimburses participating chiropractors for covered services that BCBSM deems medically necessary. Determination of medical necessity is described in Addendum A of the Physician and Professional Provider Participation Agreement (Appendix E). BCBSM reimburses chiropractors the lower of the billed charge or the maximum payment level published in BCBSM's Maximum Payment Schedule.

### BILLED CHARGE

The billed charge refers to the actual charge indicated on the claim form submitted by the provider.

### MAXIMUM PAYMENT LEVEL

Most of the Maximum Payment Schedule is based on the Resource Based Relative Value System developed by the Centers for Medicare and Medicaid Services, in which services are ranked according to the resource costs needed to provide them.

The resource costs of the RBRVS system include physician time, training, skill, risk, procedure complexity, practice overhead and professional liability insurance. Values are assigned to each service in relation to the comparative value of all other services. The relative values are then multiplied by a BCBSM-specific conversion factor to determine overall payment levels.

Maximum payment levels for all DC procedures currently reimbursed by BCBSM are based on RBRVS. If, at any time, BCBSM agrees to reimburse DCs for a procedure for which there is no Relative Value Unit, other factors may be used in setting maximum payment levels such as comparison to similar services, corporate medical policy decisions, analysis of historical charge data and geographic anomalies. BCBSM will give individual consideration to services involving

[11] http://www.chiropractic.org, 1999 data

complex treatment or unusual clinical circumstances in determining a payment that exceeds the maximum payment level.

BCBSM reviews relative values and reimbursement levels periodically and may adjust them as necessary. In addition, BCBSM may adjust maximum payment levels based on factors such as site of care or BCBSM payment policy.

An alternative reimbursement arrangement is available to groups through the Medical Surgical (MS-90) program. The MS-90 program increases reimbursement levels for purposes of reducing out-of-pocket payments in regions where participation rates are low.

## BCBSM Achievement of Access Goal

BCBSM met the access goal and objectives for the chiropractors provider class. Over 86 percent of chiropractors formally participated with BCBSM. Per-claim participation was considerably higher with 98 percent of claims accepted as paid in full. These levels of participation are attributable to BCBSM's reimbursement methodology, annual reviews and increases of reimbursement levels, and effective provider communications.

Members had access to provider listings through provider directories, the BCBSM Web site and the BCBSM Customer Service Department.

# QUALITY OF CARE GOAL PERFORMANCE

"Providers will meet and abide by reasonable standards of health care quality."

## PA 350 Quality of Care Objectives

### Objective 1

Ensure the provision of quality care to BCBSM subscribers through the application of participation qualifications and performance standards as a basis for DC participation.

### Objective 2

The Physician and Professional Provider Contract Advisory Committee meets on an ongoing basis, generally at least quarterly, to offer advice and consultation on topics such as: proposed modifications to the contract; administrative issues which may arise under the contract; medical necessity criteria and guidelines; reimbursement issues; experimental or investigational procedures; and supervision of services.

### Objective 3

Work with the Physician and Professional Provider Contract Advisory Committee (PPPCAC) to develop medical necessity criteria, as necessary.

### Objective 4

The Chiropractor's Manual will be revised, maintained and updated, to explain billing, benefits, provider appeals processes and managed care, BCBSM's record keeping requirements and an explanation of the Physician and Professional Provider Participation Agreement and its administration.

### Objective 5

Protocols and procedures relating to BCBSM's Physician Retrospective Profiling Program will be communicated to providers as they become available.

# Performance - Quality of Care Goal and Objectives

BCBSM took a threefold approach to achieving the quality of care objective for the chiropractors provider class. First, BCBSM ensured the quality of care by enforcing qualification and professional standards for participation. Second, BCBSM maintained quality controls such as documentation requirements, provider profiling and audits. Third, BCBSM promoted strong relationships with participating providers by offering various avenues for providers to receive information and to voice concerns requiring benefit coverage and or claims disputes. All of these initiatives are detailed below.

# Qualification Standards

Chiropractors must be licensed by the state of Michigan with a Michigan location to participate with BCBSM.

BCBSM routinely monitors provider eligibility and follows up on any issues that might affect patient quality of care through a verification system that is directly linked to the Michigan State Licensing Bureau. The system was developed to ensure that BCBSM maintains current and accurate information. A weekly electronic data transfer from the Michigan Department of Labor and Economic Growth identifies providers who have not renewed their licenses and are no longer eligible to practice. Based on that information, the provider identification numbers are inactivated and claims reimbursement ceases. BCBSM is also provided with information pertaining to disciplinary actions resulting in licensure suspension, revocation, or limitations. This information is used in making decisions regarding provider participation eligibility.

Other professional performance standards required for participation include absence of fraud and illegal activities and absence of inappropriate utilization/medical necessity practices as identified through proven subscriber complaints, medical necessity audits and peer review.

# Quality Controls

## Documentation Guidelines

Chiropractors must maintain documentation for all claims based on BCBSM guidelines. The guidelines ensure that procedures billed were actually performed, appropriate, reasonable and medically necessary, and that they met benefit specifications. Documentation must be legible, dated, signed with professional credentials noted and prepared as soon as possible after the service is performed. Documentation guidelines for specific types of service are included in the *Guide for Chiropractors*. General requirements include:

- Patient history
- Physical exam or clinical findings
- Diagnostic test results

- Plan, instructions, recommendations and precautions communicated to the patient and other interested parties
- Treatment rendered

## Provider Profiling

Provider profiling was an important tool for BCBSM to compare provider practices and to identify providers for audit. The primary purpose of profiling was to support appropriate, cost-effective health care services by identifying providers whose practice patterns differed from those of their peers. Upon request, practice profiles were made available to show individual provider utilization information based on paid claims. The profiles also compared the use of certain procedures to that of their peers. In 2002, 160 chiropractors requested copies of their profiles. In 2003, 69 requested copies of their profiles.

## Audits

Audits are medical record reviews that assist BCBSM in evaluating medical necessity and the quality of care provided to BCBSM members. The audit process is not designed simply to recover money. It is BCBSM's way of validating that contractual agreements were met and high quality care was given to subscribers.

During audits, BCBSM's auditors reviewed records to ensure compliance with documentation guidelines. They also compared information in providers' medical and financial records with information reported on claims. Providers are typically selected for review based on data analysis, profiling and comparative reports, prior audit history and referral from internal and external sources.

In 2002, six field audits were conducted. In 2003, there were 314 audits conducted, only seven of which were field audits. The remaining 307 were desk audits conducted to recover payments made in error for more than one office visit billed per year or more than one mechanical traction service billed per day. BCBSM claim systems have been corrected to avoid this problem in the future.

Initial savings identified as a result of the audits during the reporting period totaled over $1.2 million. The amount recovered through December 2004 is $165,330 with potential additional recoveries of $1,007,840. The finalized recoveries for 2003 include 294 desk audits and no field audits. Significant audit findings included:

- Documentation did not support medical necessity of service performed.
- Documentation guidelines not met.
- Evaluation and management codes billed in excess of benefit limitations.
- Over-utilization of x-rays.
- Unbundling of x-rays (incorrect coding).
- Emergency visit (99058) billed for each chiropractor visit or adjustment in order to receive payment for patients who otherwise had no chiropractic benefits.

A summary of audit activity is included below in Table 10.

**Table 10**
**Chiropractors Provider Class**
**Audit Performance 2003 - 2002**

| | 2003 | 2002 |
|---|---|---|
| Number of Audits | 314 | 6 |
| Initial Identified Savings | $939,450 | $321,874 |
| Finalized Recoveries | $146,580 | $18,750 |
| Pending Recoveries | $728,252 | $279,588 |
| Referred to Corporate Financial Investigation | 1 | 1 |

Note – the figures above differ slightly from those previously reported due to inclusion of recoveries through December 31, 2004 and the review of BCBSM audit logs which resulted in some corrections.

# Provider Relations

In addition to enforcing provider qualifications and upholding quality controls, BCBSM maintained relations with chiropractors during the review period. BCBSM achieved this through various means such as provider communications and by offering providers a formal appeals process. Specialty liaison society meetings provided a forum to discuss issues.

## Provider Communications

BCBSM informed chiropractors of its policies and procedures through regular meetings with the PPPCAC, provider publications, and provider inquiry departments.

The PPPCAC is a collaborative council made up of representatives of BCBSM and providers such as chiropractors. Their meetings offer the opportunity to discuss issues with BCBSM on a regular basis. The two DC representatives on the PPPCAC in 2002 and 2003 were the heads of the Michigan Chiropractic Society and the Michigan Chiropractic Association. The DCs participated in the April and October meetings each year. Topics discussed included BCBSM cost performance, including chiropractors' cost performance, BCBSM initiatives and BCBSM's physician and professional provider fee update evaluation and recommendations.

In January 2003, BCBSM consolidated *The Record, Hospital and Facility News,* and *Service News* into one redesigned monthly newsletter called *The Record*. Provider focus groups participated in the redesign process. The consolidation was part of an ongoing effort to improve communications with providers and to make BCBSM information more accessible to them. Participating and some non-participating chiropractors received *The Record,* which communicated important, current information pertinent to the timely and efficient servicing of BCBSM members, including policy changes, group specific benefit changes, and other provider-specific issues. Additionally, BCBSM's Provider Consulting Services built relationships with providers through enhanced visibility, communication and consultative services.

Formally participating chiropractors received a comprehensive manual called *Guide for Chiropractors.* The manual provides detailed instructions for servicing BCBSM members. It is updated as necessary and is designed to clarify BCBSM policies, eligibility criteria and benefit guidelines**.** In 2000, BCBSM began revisions to the *Guide for Chiropractors* to accommodate the recommendations of the Michigan Chiropractic Society and the Michigan Chiropractic Association. This project is still underway and a new on-line manual will be available shortly. In the interim, a manual on CD-ROM was mailed to participating DCs in July 2004. Topics detailed in the manual include:

- Member eligibility requirements
- Benefits and exclusions
- Criteria and guidelines for services
- Documentation guidelines
- Claim submission information
- Appeals process
- Utilization Management
- BCBSM departments to contact for clarification of issues

BCBSM offered chiropractors the options of speaking with provider service representatives, writing to our inquiry department, and having a provider consultant visit provider offices to help guide and educate their staff. In addition, BCBSM held training seminars on various topics such as benefits, claim processing and adjustments. These were available to all professional providers.

The BCBSM Web site has a section for providers with information on benefits and eligibility, how to contact us and continuing medical education. In 2003, there was an average of 16,000 provider hits to the site per month.

There are also other avenues for providers to obtain information. CAREN$^{+}$, an integrated voice response system, provides information on eligibility, benefits, deductibles and copayments. Web-DENIS, a computerized provider inquiry program, provides patient's contract eligibility coverage, benefits, coordination of benefits, claims tracking and facility claim correction. Web-DENIS, unlike CAREN$^{+}$, provides claims status information and offers historical eligibility.

Ongoing communication with chiropractors enhanced relationships with them, impacting both per-claim and formal participation.

## Provider Appeals Process

In accordance with PA 350, sections 402(1), 403 and 404, BCBSM makes a formal appeals process available to chiropractors. A description of the process can be found in Addendum E of the Physician and Professional Provider Participation Agreement located in Appendix E. The appeals process serves to resolve claim or audit disagreements. Chiropractors are informed of the appeals process through *The Record,* the provider manual, and the Physician and Professional Provider Participation Agreement.

At the beginning of 2002, there were two cases pending determination from OFIS and BCBSM received an additional eight requests for determination during that year. One case was settled, leaving nine cases pending at year-end. In 2003, nineteen requests for determination from OFIS were received. Three cases were settled prior to OFIS determination, one was dismissed, and 16 were decided by OFIS (15 in BCBSM's favor and one in favor of the provider). There were a total of eight cases pending at year-end.

## BCBSM Achievement of Quality of Care Goal

BCBSM achieved the quality of care goal in three ways. First, providers were required to meet qualification standards to ensure that they were capable of rendering high quality care to BCBSM members. Qualification status was continuously monitored. Next, BCBSM's quality controls included documentation requirements to ensure that services rendered were medically necessary and appropriate to the patient's condition. Other quality controls included provider profiling and audits which ensured providers were conducting business in accordance with their contractual agreement. Thirdly, BCBSM provided chiropractors with a formal provider appeals process and communicated up-to-date information through BCBSM's publications, inquiry systems and provider consultants. BCBSM kept providers well informed by providing them with the resources necessary to service BCBSM members in a high quality manner.

# CONCLUSION

The 2.9 percent PA 350 cost goal was met. The two-year average decrease in payments per 1000 members of 1.9 percent was the result of an average decrease in utilization of 4.9 percent and an average increase in payment per service of 3.3 percent. The decrease in utilization is attributable to the decrease in membership as members migrated to managed care coverage and a lower percentage of members using chiropractic benefits. In contrast, the number of services per patient increased slightly.

Adequate subscriber access to chiropractors was achieved in several ways. BCBSM offered licensed providers the opportunity to participate by signing a formal participation agreement. Chiropractors were also able to participate on a per-claim basis, resulting in approximately 98 percent of services being paid in full. This level of access minimized member out-of-pocket expenses. Effective provider communications, BCBSM's reimbursement methodology and annual review of reimbursement levels also combined to meet the access goal.

Finally, the quality of care goal was met through several means. In addition to requiring chiropractors to be fully licensed and comply with specific documentation guidelines, BCBSM relied on utilization review audits, provider profiling, provider relations efforts and the appeals process to ensure that members received quality care.

These actions supported BCBSM's commitment to ensure that only cost-effective, accessible and high quality care was rendered by chiropractors serving BCBSM's members.

# APPENDIX A

## Overview of Public Act 350

This section briefly describes the provider class plan annual reporting requirements mandated under Public Act 350.

### ANNUAL REPORTING REQUIREMENTS

The provider class plan annual reports are submitted pursuant to section 517 of PA 350, which requires BCBSM to submit to the Commissioner an annual report for each provider class that shows the level of BCBSM's achievement of the goals provided in section 504.

### PA 350 GOALS

The term "goals", used in section 517 above, refers to specific cost, access and quality goals described in section 504. This section states:

"A health care corporation shall, with respect to providers, contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to, and reasonable cost and quality of health care services in accordance with the following goals:

### COST GOAL

"Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth." This is expressed by the following formula:

$$\frac{((100 + I) \times (100 + REG))}{(100)} - 100$$

### ACCESS GOAL

"There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

### QUALITY OF HEALTH CARE GOAL

"Providers will meet and abide by reasonable standards of health care quality."

# Calculation of 2000 – 2001 Cost Goal

Using the population and economic assumptions in the table below, the cost goal for the period is estimated to be **2.868%**.

Inflation = **1.412%**
Real Economic Growth = **1.455%**

$$\frac{((100 + \mathbf{1.412\%}) \times (100 + \mathbf{1.455\%}))}{(100)} - 100 = \mathbf{2.868\%}$$

**PA 350 COST GOAL ASSUMPTIONS**

| Year | Population (1) | Real GDP(2) ($millions) | Per Capita GDP | Implicit Price Deflator(2) | Percent Change in : Per Capita GDP | Percent Change in : IPD |
|---|---|---|---|---|---|---|
| **1999** | 272,820,000 | $9,470.3 | $34,712.63 | 97.87 | | |
| **2000** | 275,306,000 | $9,817.0 | $35,658.50 | 100.00 | **2.725%** | **2.178%** |
| **2001** | 277,803,000 | $9,866.6 | $35,516.54 | 102.73 | **-0.398%** | **2.730%** |
| **2002** | 280,306,000 | $10,083.0 | $35,971.40 | 103.95 | **1.281%** | **1.183%** |
| **2003** | 282,798,000 | $10,397.7 | $36,767.23 | 105.65 | **2.212%** | **1.642%** |

**Sources**
(1) Middle series population estimates and projections programs revised 2/14/00; www.census.gov/population/projections

(2) Department of Commerce, Bureau of Economic Analysis, reported in *Economic Indicators*, February 2004;

## Definitions

Section 504 of the Act also provides the following definitions for terms used in the cost goal calculation:

"**'Gross Domestic Product (GDP) in constant dollars'** means that term as defined and annually published by the United States Department of Commerce, Bureau of Economic Analysis."

"**'Implicit price deflator for gross national product'** means that term as defined and annually published by the United States Department of Commerce, Bureau of Economic Analysis."

"**'Inflation'** (**I**) means the arithmetic average of the percentage changes in the implicit price deflator for gross national product over the 2 calendar years immediately preceding the year in which the commissioner's determination is being made."

"**'Compound rate of inflation and real economic growth'** means the ratio of the quantity 100 plus inflation multiplied by the quantity 100 plus real economic growth to 100; minus 100."

"**'Rate of change in the total corporation payment per member to each provider class'** means the arithmetic average of the percentage changes in the corporation payment per member for that provider class over the 2 years immediately preceding the Commissioner's determination."

"**'Real economic growth'** (**REG**) means the arithmetic average of the percentage changes in the per capita gross national product in constant dollars over the 4 calendar years immediately preceding the year in which the commissioner's determination is being made."

## Determination Process

Under PA 350, the commissioner is required to consider information presented in the annual report, as well as all other relevant factors that might affect the performance of a particular provider class, in making a determination with respect to that class.

Section 509 of the Act outlines factors that should be considered by the commissioner to "determine if the health care corporation has substantially achieved the goals of a corporation as provided in section 504 and achieved the objectives contained in the provider class plan." Many of these factors are beyond BCBSM's direct control and may adversely impact the cost and use of health care services for a particular provider class. Specifically, section 509(4) states:

*The commissioner shall consider all of the following in making a determination...*:

*(a) Annual reports transmitted pursuant to section 517.*

*(b) The overall balance of the goals provided in section 504, achieved by the health care corporation under the plan. The commissioner shall give weight to each of the goals provided in section 504, shall not focus on one goal independently of the other goals of the corporation, and shall assure that no portion of the corporation's fair share of reasonable costs to the provider are borne by other health care purchasers.*

*(c) Information submitted or obtained for the record concerning*:

- *Demographic trends;*
- *Epidemiological trends;*
- *Long-term economic trends, including changes in prices of goods and services purchased by a provider class not already reflected in the calculation in section 504(2)(d);*
- *Sudden changes in circumstances;*
- *Administrative agency or judicial actions;*
- *Changes in health care practices and technology; and,*

- *Changes in benefits that affect the ability of the health care corporation to reasonably achieve the goals provided in section 504.*

*(d) Health care legislation of this state or of the federal government. As used in this subdivision, 'health care legislation' does not include Act No. 218 of the Public Acts of 1956, as amended, being sections 500.100 to 500.8302 of the Michigan Compiled Laws.*

*(e) Comments received from an individual provider of the appropriate provider group, or from an organization or association that represents the appropriate provider class, and comments received pursuant to section 505(2).*

*After considering the information and factors described in section 509(4), the goals of a health care corporation as provided in sections 504, and the objectives contained in the provider class plan, the commissioner shall determine one of the following [as stated under section 510(1)]:*

*(a) That the provider class plan achieves the goals of the corporation as provided in section 504.*

*(b) That although the provider class plan does not substantially achieve one or more of the goals of the corporation, a change in the provider class plan is not required because there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve one or more of the goals was reasonable due to factors listed in section 509(4).*

*(c) That a provider class plan does not substantially achieve one or more of the goals of the corporation as provided in section 504.*

*A determination made by the commissioner under section 510 1(a) or 1(b) would require no further action by the corporation. Upon a 511(1)(c) determination by the commissioner, under section 511, the corporation*:

*(1) Within 6 months or a period determined by the commissioner..., shall transmit to the commissioner a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the commissioner pursuant to section 510(2). In developing a provider class plan under this subsection, the corporation shall obtain advice and consultation from providers in the provider class and subscribers, using procedures established pursuant to section 505.*

*(2) If after 6 months or a period determined by the commissioner..., the health care corporation has failed to act pursuant to subsection (1), the commissioner shall prepare a provider class plan..., for that provider class.*

The findings of the commissioner may be disputed by any party through an appeals process available under section 515 of PA 350.

# APPENDIX B

## Technical Notes

The data indices presented in the 2001, 2002, and 2003 databases and analyzed in the annual reports reflect a defined subset of BCBSM claims experience. The data specifications and collection methodologies are discussed in the following sections.

### Data Elements and Collection

The basic statistics analyzed for each provider class are total payments and utilization, from which an average price per utilization unit is derived. These data were collected from BCBSM data files that are based on claims submitted to the Corporation and approved for payment to the provider or in some cases, the subscriber.

The data collection period captures health care services incurred during specific twelve-month calendar years and paid through fourteen months. For example, the 2003 dataset includes all services incurred between 1/1/03 and 12/31/03, and paid from 1/1/03 through 2/29/04. It is reasonable to expect that for the chiropractors provider class, approximately 95 percent of total experience is captured.

Participation rates are based on providers who sign a BCBSM participation agreement and the total number of licensed providers registered with BCBSM.

### Scope of the Data

1. PROVIDER CLASS ACCOUNTABILITY

   PA 350 requires BCBSM to report its Traditional line of business for the purposes of provider class accountability. Underwritten groups and administrative services contracts are included.

   The data excludes complementary claims and members, the Federal Employee Program and non-Michigan liability such as claims paid through the Inter-Plan Teleprocessing System for out-of-state Blue members. Claims incurred out-of-state by BCBSM members are also excluded.

   Community Blue and other BCBSM PPO products, Blue Care Network, and Blue Choice®, BCBSM's Point of Service, product are excluded from the reporting requirements referred to in PA 350 Section 502(a) (11) and the HMO Act.

## 2. REGIONAL EXPERIENCE

Regions selected for analysis are compatible with Michigan Metropolitan Statistical Areas (MSAs) and provide an acceptable basis for analysis of access as well as of provider practice patterns.

The data cover total Traditional business, divided into nine regions. Regions one through nine represent groups of Michigan counties. Michigan claims experience with unidentified zip codes was allocated among the nine regions according to the distribution of data with identifiable zip codes.

## 3. MEMBERSHIP

This report includes all BCBSM Traditional members residing in Michigan.

The regions used for analysis pertain to the location where services were delivered. For example, region one experience represents payments to region one providers for services rendered to BCBSM members regardless of residency. This is because subscribers who live in one region may receive services in another region because they reside near a border or want services from a provider in another region.

# APPENDIX C

## Cost, Use and Price Data

- Cost, Use and Price Experience by Procedure Category
- Cost, Use and Price Experience by Place of service
- Summary of Regional Performance
- Detailed Regional Data
- Administrative Service Contracts, by Region

### Chiropractors
### Cost, Use and Price Experience by Procedure Category
### 2003-2001

| Year | Procedure Category | Payments | Services | Per 1000 Members Payments | Services | Pymt/Svc | Percent change of Pymts/1000 | Svcs/1000 | Pymt/Svc |
|---|---|---|---|---|---|---|---|---|---|
| 2003 | Manipulation Of Spine | $27,270,404.95 | 819,943 | $ 38,839.54 | 1,167.79 | $ 33.26 | 4.4% | 4.1% | 0.3% |
| 2003 | Radiologic Exam | $3,395,115.22 | 78,612 | $ 4,835.45 | 111.96 | $ 43.19 | -15.2% | -13.2% | -2.3% |
| 2003 | Traction, Mechanical | $2,456,631.54 | 144,263 | $ 3,498.83 | 205.46 | $ 17.03 | -13.5% | -7.0% | -7.0% |
| 2003 | Office Visits | $502,444.17 | 11,511 | $ 715.60 | 16.39 | $ 43.65 | -23.4% | -27.4% | 5.5% |
| 2003 | All Others | $234,778.12 | 13,638 | $ 334.38 | 19.42 | $ 17.21 | -14.6% | -28.4% | 19.3% |
| | **Total** | $ 33,859,374 | 1,067,967 | $ 48,223.80 | 1,521.04 | $ 31.70 | -0.1% | -0.1% | -0.1% |

| Year | Procedure Category | Payments | Services | Per 1000 Members Payments | Services | Pymt/Svc | Pymts/1000 | Svcs/1000 | Pymt/Svc |
|---|---|---|---|---|---|---|---|---|---|
| 2002 | Manipulation Of Spine | $ 28,250,084 | 851,852 | $ 37,220.14 | 1,122.33 | $ 33.16 | -0.2% | -6.4% | 6.6% |
| 2002 | Radiologic Exam | $ 4,327,225 | 97,898 | $ 5,701.22 | 128.98 | $ 44.20 | -8.1% | -9.7% | 1.8% |
| 2002 | Traction, Mechanical | $ 3,071,510 | 167,740 | $ 4,046.78 | 221.00 | $ 18.31 | -15.9% | -21.4% | 7.0% |
| 2002 | Office Visits | $ 709,431 | 17,148 | $ 934.69 | 22.59 | $ 41.37 | -29.8% | -35.9% | 9.5% |
| 2002 | All Others | $ 297,098 | 20,593 | $ 391.43 | 27.13 | $ 14.43 | -21.3% | -3.1% | -18.8% |
| | **Total** | $ 36,655,347 | 1,155,231 | $ 48,294.27 | 1,522.04 | $ 31.73 | -3.7% | -9.7% | 6.7% |

| Year | Procedure Category | Payments | Services | Per 1000 Members Payments | Services | Pymt/Svc |
|---|---|---|---|---|---|---|
| 2001 | Manipulation Of Spine | $ 29,979,716 | 963,271 | $ 37,307.00 | 1,198.70 | $ 31.12 |
| 2001 | Radiologic Exam | $ 4,984,142 | 114,752 | $ 6,202.31 | 142.80 | $ 43.43 |
| 2001 | Traction, Mechanical | $ 3,867,395 | 225,957 | $ 4,812.62 | 281.18 | $ 17.12 |
| 2001 | Office Visits | $ 1,069,677 | 28,310 | $ 1,331.11 | 35.23 | $ 37.78 |
| 2001 | All Others | $ 399,474 | 22,490 | $ 497.11 | 27.99 | $ 17.76 |
| | **Total** | $ 40,300,405 | 1,354,780 | $ 50,150.14 | 1,685.90 | $ 29.75 |

# Chiropractors Cost, Use, and Price Experience
# By Place of Service 2003-2001

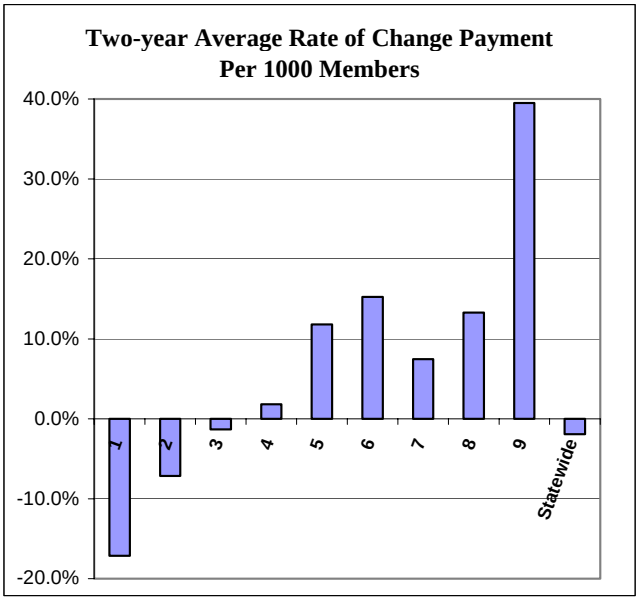
| Year | Payments | Services | Per 1000 Members Payments | Services | Pymts/Svc | Percent change of Pymts/1000 | Svcs/1000 | Pymt/Svc |
|---|---|---|---|---|---|---|---|---|
| 2003 Office | $33,608,141.61 | 1,058,914 | $ 47,865.98 | 1,508.15 | $ 31.74 | 0.0% | 0.2% | -0.2% |
| 2003 Inpatient Hospital | $122,491.34 | 4,438 | $ 174.46 | 6.32 | $ 27.60 | -47.6% | -47.6% | 0.0% |
| 2003 Other | $87,397.96 | 3,333 | $ 124.48 | 4.75 | $ 26.22 | 25.1% | 8.1% | 15.7% |
| 2003 Outpatient Hospital | $41,342.75 | 1,282 | $ 58.88 | 1.83 | $ 32.25 | 296.4% | 242.2% | 15.8% |
| **Total** | $33,859,373.66 | 1,067,967 | $ 48,223.80 | 1,521.04 | $ 31.70 | -0.1% | -0.1% | -0.1% |

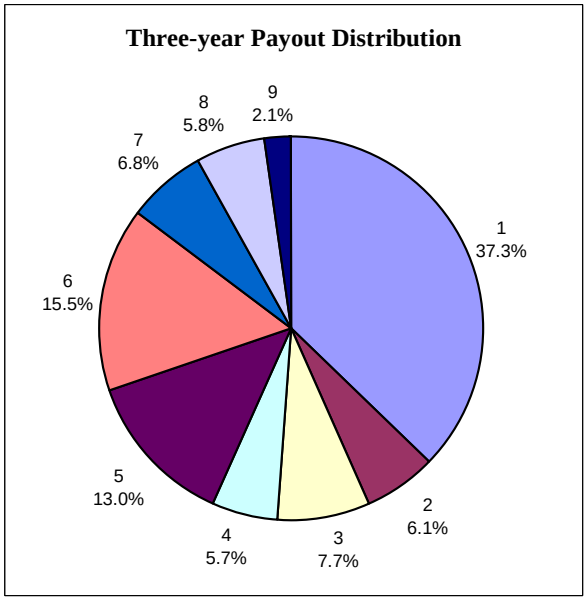
| Year | Payments | Services | Per 1000 Members Payments | Services | Pymts/Svc | Percent change of Pymts/1000 | Svcs/1000 | Pymt/Svc |
|---|---|---|---|---|---|---|---|---|
| 2002 Office | $36,315,631.32 | 1,142,331 | $ 47,846.68 | 1,505.05 | $ 31.79 | -4.0% | -10.0% | 6.7% |
| 2002 Inpatient Hospital | $252,900.85 | 9,162 | $ 333.20 | 12.07 | $ 27.60 | 37.5% | 32.4% | 3.8% |
| 2002 Other | $75,540.27 | 3,333 | $ 99.53 | 4.39 | $ 22.66 | 72.4% | 26.3% | 36.5% |
| 2002 Outpatient Hospital | $11,274.89 | 405 | $ 14.85 | 0.53 | $ 27.84 | -18.3% | -22.5% | 5.3% |
| **Total** | $36,655,347.33 | 1,155,231 | $ 48,294.27 | 1,522.04 | $ 31.73 | -3.7% | -9.7% | 6.7% |

| Year | Payments | Services | Per 1000 Members Payments | Services | Pymts/Svc |
|---|---|---|---|---|---|
| 2001 Office | $40,044,636.00 | 1,344,109 | $ 49,831.86 | $ 1,672.62 | $ 29.79 |
| 2001 Inpatient Hospital | $194,759.61 | 7,325 | $ 242.36 | $ 9.12 | $ 26.59 |
| 2001 Other | $46,390.24 | 2,793 | $ 57.73 | $ 3.48 | $ 16.61 |
| 2001 Outpatient Hospital | $14,619.59 | 553 | $ 18.19 | $ 0.69 | $ 26.44 |
| **Total** | $40,300,405.44 | 1,354,780 | $ 50,150.14 | $ 1,685.90 | $ 29.75 |

## CHIROPRACTORS PROVIDER CLASS
## Summary of Cost, Use and Price Performance by Region 2003-2001

| Region | Two-year average rate of change | | | Three-year Payout | % of Total Payout |
|---|---|---|---|---|---|
| | Payments Per 1000 Members | Services Per 1000 Members | Payment Per Service | | |
| 1 | -17.1% | -17.6% | 1.5% | $ 41,363,867 | 37.3% |
| 2 | -7.2% | -9.8% | 3.2% | $ 6,712,357 | 6.1% |
| 3 | -1.3% | -5.6% | 5.0% | $ 8,541,775 | 7.7% |
| 4 | 1.8% | -0.7% | 2.4% | $ 6,330,472 | 5.7% |
| 5 | 11.8% | 6.8% | 4.7% | $ 14,363,305 | 13.0% |
| 6 | 15.2% | 9.7% | 5.0% | $ 17,229,138 | 15.5% |
| 7 | 7.5% | 3.7% | 3.4% | $ 7,500,770 | 6.8% |
| 8 | 13.3% | 7.4% | 5.0% | $ 6,405,887 | 5.8% |
| 9 | 39.5% | 31.1% | 3.3% | $ 2,367,555 | 2.1% |
| **Statewide** | **-1.9%** | **-4.9%** | **3.3%** | **$110,815,126** | **100.0%** |



# Chiropractors
# Cost, Use, and Price Performance by Region
# 2003-2001

| Year | Region | Payments | Services | Members | Per 1000 Members Payment | Services | Pyt/Svc | Percent change of Pymts/1000 | Svcs/1000 | Pyt/Svc |
|---|---|---|---|---|---|---|---|---|---|---|
| 2003 | 1 | $12,055,565 | 390,370 | 272,971 | $44,164 | 1,430 | $30.88 | -4.9% | -1.8% | -3.2% |
| 2003 | 2 | $2,015,457 | 66,070 | 39,365 | $51,200 | 1,678 | $30.50 | -4.2% | -2.9% | -1.3% |
| 2003 | 3 | $2,760,436 | 78,080 | 74,139 | $37,233 | 1,053 | $35.35 | 10.0% | 7.9% | 2.0% |
| 2003 | 4 | $1,844,978 | 55,258 | 31,460 | $58,645 | 1,756 | $33.39 | -7.0% | -5.5% | -1.6% |
| 2003 | 5 | $4,831,768 | 155,919 | 80,207 | $60,241 | 1,944 | $30.99 | 9.0% | 5.7% | 3.1% |
| 2003 | 6 | $5,797,410 | 175,291 | 98,123 | $59,083 | 1,786 | $33.07 | 12.4% | 8.5% | 3.6% |
| 2003 | 7 | $2,180,267 | 71,176 | 61,975 | $35,180 | 1,148 | $30.63 | -5.6% | -6.2% | 0.6% |
| 2003 | 8 | $1,768,285 | 55,893 | 27,930 | $63,312 | 2,001 | $31.64 | -5.7% | -7.6% | 2.1% |
| 2003 | 9 | $605,207 | 19,910 | 15,961 | $37,918 | 1,247 | $30.40 | -25.9% | -22.9% | -4.0% |
| | **Total** | **$33,859,374** | **1,067,967** | **702,130** | **$48,224** | **1,521** | **$31.70** | **-0.1%** | **-0.1%** | **-0.1%** |

| Year | Region | Payments | Services | Members | Per 1000 Members Payment | Services | Pyt/Svc | Percent change of Pymts/1000 | Svcs/1000 | Pyt/Svc |
|---|---|---|---|---|---|---|---|---|---|---|
| 2002 | 1 | $13,379,927 | 419,423 | 288,051 | $46,450 | 1,456 | $31.90 | -29.4% | -33.5% | 6.2% |
| 2002 | 2 | $2,292,517 | 74,159 | 42,885 | $53,458 | 1,729 | $30.91 | -10.1% | -16.6% | 7.8% |
| 2002 | 3 | $2,760,396 | 79,617 | 81,540 | $33,853 | 976 | $34.67 | -12.6% | -19.2% | 8.1% |
| 2002 | 4 | $2,193,824 | 64,677 | 34,780 | $63,078 | 1,860 | $33.92 | 10.6% | 4.1% | 6.3% |
| 2002 | 5 | $4,703,183 | 156,536 | 85,128 | $55,248 | 1,839 | $30.05 | 14.6% | 7.8% | 6.3% |
| 2002 | 6 | $5,815,880 | 182,161 | 110,621 | $52,575 | 1,647 | $31.93 | 18.1% | 10.9% | 6.5% |
| 2002 | 7 | $2,514,218 | 82,599 | 67,478 | $37,260 | 1,224 | $30.44 | 20.5% | 13.6% | 6.1% |
| 2002 | 8 | $2,153,015 | 69,455 | 32,065 | $67,145 | 2,166 | $31.00 | 32.3% | 22.5% | 8.0% |
| 2002 | 9 | $842,387 | 26,603 | 16,453 | $51,200 | 1,617 | $31.66 | 104.9% | 85.1% | 10.7% |
| | **Total** | **$36,655,347** | **1,155,231** | **759,000** | **$48,294** | **1,522** | **$31.73** | **-3.7%** | **-9.7%** | **6.7%** |

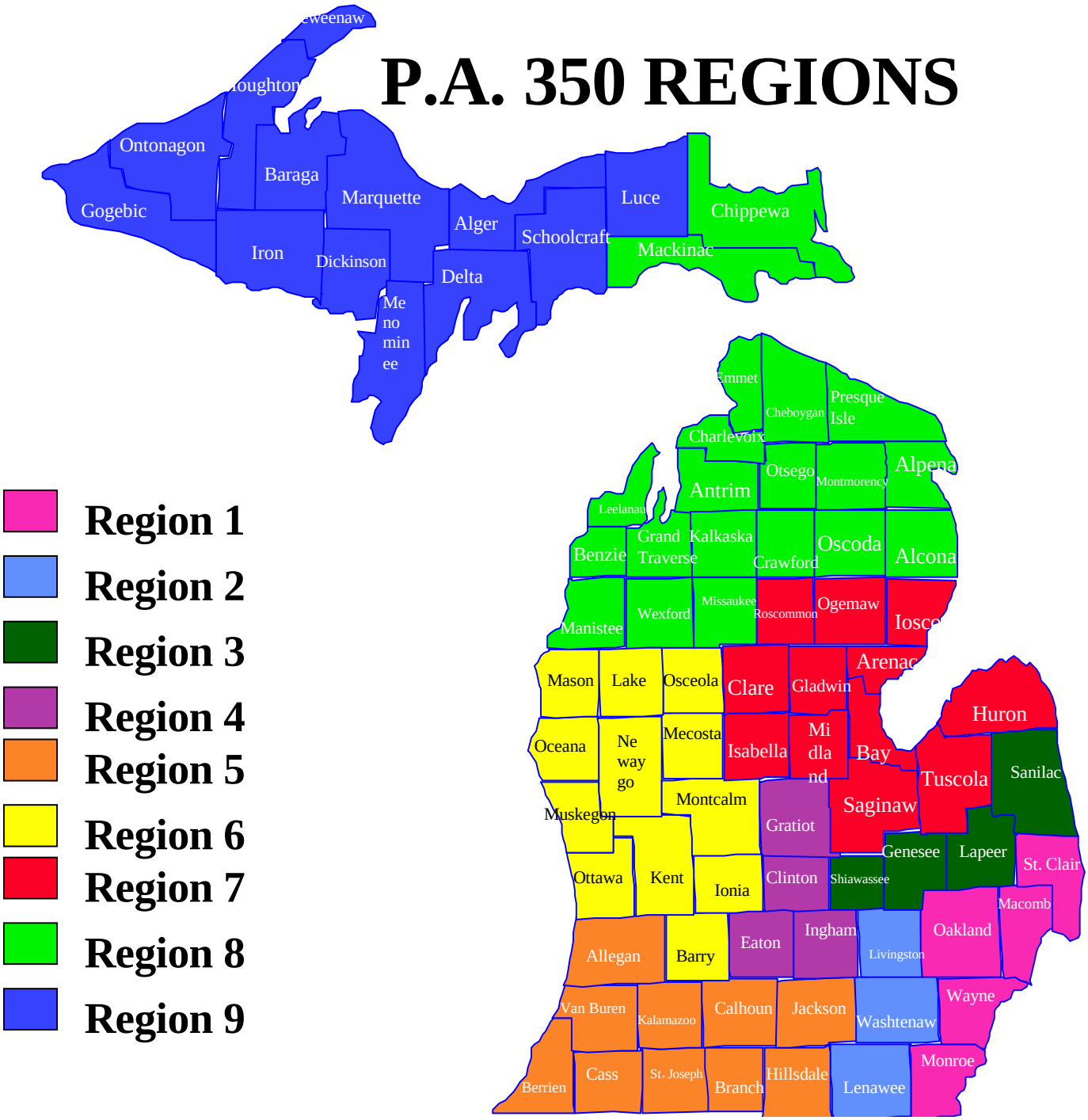
| Year | Region | Payments | Services | Members | Per 1000 Members Payment | Services | Pyt/Svc |
|---|---|---|---|---|---|---|---|
| 2001 | 1 | $15,928,375 | 530,352 | 242,187 | $65,769 | 2,190 | $30.03 |
| 2001 | 2 | $2,404,383 | 83,839 | 40,441 | $59,454 | 2,073 | $28.68 |
| 2001 | 3 | $3,020,943 | 94,171 | 77,974 | $38,743 | 1,208 | $32.08 |
| 2001 | 4 | $2,291,670 | 71,837 | 40,196 | $57,013 | 1,787 | $31.90 |
| 2001 | 5 | $4,828,354 | 170,796 | 100,137 | $48,217 | 1,706 | $28.27 |
| 2001 | 6 | $5,615,848 | 187,247 | 126,137 | $44,522 | 1,484 | $29.99 |
| 2001 | 7 | $2,806,286 | 97,787 | 90,752 | $30,922 | 1,078 | $28.70 |
| 2001 | 8 | $2,484,586 | 86,591 | 48,952 | $50,756 | 1,769 | $28.69 |
| 2001 | 9 | $919,961 | 32,160 | 36,818 | $24,987 | 873 | $28.61 |
| | **Total** | **$40,300,405** | **1,354,780** | **803,595** | **$50,150** | **1,686** | **$29.75** |

## Chiropractors
## Administrative Service Contracts, by Region
## 2003-2001

| Region | 2003 | | | 2002 | | | 2001 | | |
|---|---|---|---|---|---|---|---|---|---|
| | ASC Payments | Total Payments | ASC % | ASC Payments | Total Payments | ASC % | ASC Payments | Total Payments | ASC % |
| 1 | $5,208,166 | $12,055,565 | 43.2% | $6,225,344 | $13,379,927 | 46.5% | $6,494,794 | $15,928,375 | 40.8% |
| 2 | $565,538 | $2,015,457 | 28.1% | $864,729 | $2,292,517 | 37.7% | $823,950 | $2,404,383 | 34.3% |
| 3 | $572,438 | $2,760,436 | 20.7% | $854,146 | $2,760,396 | 30.9% | $1,023,547 | $3,020,943 | 33.9% |
| 4 | $357,272 | $1,844,978 | 19.4% | $796,518 | $2,193,824 | 36.3% | $835,717 | $2,291,670 | 36.5% |
| 5 | $1,162,969 | $4,831,768 | 24.1% | $1,415,571 | $4,703,183 | 30.1% | $1,315,659 | $4,828,354 | 27.2% |
| 6 | $1,099,870 | $5,797,410 | 19.0% | $1,531,074 | $5,815,880 | 26.3% | $1,681,003 | $5,615,848 | 29.9% |
| 7 | $548,866 | $2,180,267 | 25.2% | $896,116 | $2,514,218 | 35.6% | $1,013,998 | $2,806,286 | 36.1% |
| 8 | $312,639 | $1,768,285 | 17.7% | $693,558 | $2,153,015 | 32.2% | $746,324 | $2,484,586 | 30.0% |
| 9 | $134,324 | $605,207 | 22.2% | $377,189 | $842,387 | 44.8% | $357,296 | $919,961 | 38.8% |
| **Total** | **$9,962,084** | **$33,859,374** | **29.4%** | **$13,654,245** | **$36,655,347** | **37.3%** | **$14,292,287** | **$40,300,405** | **35.5%** |

# APPENDIX D

# P.A. 350 REGIONS



# APPENDIX E – Physician and Professional Provider Participation Agreement (Attached)